EXHIBIT B
PART 1

Employer: SLAVIN & SLAVIN

Group Number: 600662

CERTIFICATE OF INSURANCE

Humana Insurance Company

This Certificate is not an insurance policy. It is an outline of the insurance provided by the group policy and it does not extend or change the coverage afforded by such group policy. The insurance described by this Certificate is subject to all the provisions, terms, exclusions and conditions of the group policy.

This Certificate supersedes and replaces any Certificate previously issued under the provisions of the group policy.

IMPORTANT NOTICE

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan as paid its portion of the bill. Participating providers have agreed to accept discounted payments for service with no additional billing to the member other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll fee telephone number on your identification card.

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SCHEDULE OF BENEFITS

BENEFITS ARE PAYABLE ONLY IF **SERVICES** ARE CONSIDERED TO BE A **COVERED EXPENSE** AND ARE **MEDICALLY NECESSARY**. ALL COVERED **SERVICES** ARE PAYABLE ON A **MAXIMUM ALLOWABLE FEE** BASIS AND ARE SUBJECT TO SPECIFIC CONDITIONS, DURATIONAL LIMITATIONS AND ALL APPLICABLE MAXIMUMS OF THIS POLICY.

This Schedule of Benefits is part of **Your** Certificate.

The benefits outlined in this Schedule of Benefits are a summary of coverage and limitations provided under this group Policy. A more detailed explanation of **Your** coverage, limitations and exclusions is also provided in **Your** Certificate. Please refer to the Certificate and any applicable riders for additional coverage and/or limitations.

PREFERRED PROVIDER ORGANIZATION PROVISION

Your Certificate contains a Preferred Provider Organization Provision. Benefits may be paid at an increased percentage if **Services** are provided by a Preferred Provider. Please see the schedule of Medical Benefits and Covered Services.

PRESERVICE NOTIFICATION

Your Certificate contains procedures **You** must follow if **You** or a covered **Dependent** are to be admitted to a **Hospital** or **Qualified Treatment Facility** or are to have non-emergency outpatient **Surgery.** These procedures are described in the Utilization Management section of **Your** Certificate.

If **You** do not notify **Us** prior to an inpatient **Confinement** or non-emergency outpatient **Surgery**, benefits will NOT be payable for the first $500 of **Covered Expense**.

The $500 penalty is NOT applied to the **Deductible** or **Out-of-Pocket** limits shown on this Schedule of Benefits.

PREAUTHORIZATION REQUIREMENTS

Your Certificate contains procedures **You** must follow if **You** or a **Covered Dependent** are to receive **Services** from a **Skilled Nursing Facility, Hospice Facility** or **Home Health Care Provider.** These procedures are described in the Covered Services section of **Your** Certificate.

SCHEDULE OF BENEFITS (continued)

Lifetime Maximum Benefit per **Covered Person**.....$5,000,000

Calendar Year **Deductible**:

- $250 per **Covered Person** when **You** see a Preferred Provider
- $250 per **Covered Person** when **You** see a Non-Preferred Provider

Any **Covered Expense** incurred by **You** during the last three months of the calendar year that is used to satisfy all or part of the **Deductible** for that calendar year will be used to satisfy all or part of the **Deductible** for the following Calendar Year.

Maximum Family Calendar Year plan **Deductible**:

- **Covered Expenses** applied to each **Covered Person's** plan **Deductible** are combined to a maximum family **Deductible** of $750.

Out-of-Pocket Limit

Individual Out-of-Pocket Limit:

After the **Deductible**, if all the combined **Covered Expense You** pay for **Coinsurance** totals:

- $1,000 when **You** see a Preferred Provider; and
- $6,000 when **You** see a Non-Preferred Provider

in a calendar year, **We** will then pay **Covered Expense** at 100% for the remainder of that calendar year, subject to copayments, if any, and the Lifetime Maximum Benefit. The combined Preferred Provider and Non-Preferred Provider **Out-of-Pocket Limit** is $6,000 after the **Deductible**.

Family Out-of-Pocket Limit:

If the combined **Covered Expense You** and **Your** Covered **Dependents** pay for **Deductible** and **Coinsurance** totals:

- $3,750 when **You** or **Your** Covered **Dependents** see a Preferred Provider; and
- $18,750 when **You** or **Your** Covered **Dependents** see a Non-Preferred Provider

in a calendar year, **We** will then pay **Covered Expense** at 100% for the remainder of that calendar year, subject to copayments, if any, and the Lifetime Maximum Benefit. The combined Preferred Provider and Non-Preferred Provider **Out-of-Pocket Limit** is $18,750 including the **Deductible**.

SCHEDULE OF BENEFITS (continued)

ALL **SERVICES** ARE SUBJECT TO ALL THE TERMS AND PROVISIONS, LIMITATIONS AND EXCLUSIONS OF THE POLICY

SUMMARY OF SERVICES

(DOES NOT INCLUDE MENTAL HEALTH COVERED **SERVICES**)

HOSPITAL SERVICES

Inpatient Care

- Semi-Private Room
- Intensive Care Unit
- Operating Room
- Ancillary **Services**

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

OUTPATIENT CARE (HOSPITAL ONLY) - ALL SERVICES

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

PHYSICIAN SERVICES

- Routine and Diagnostic Office visits
- Home visits billed by the physician
- Diagnostic Radiology, Laboratory, Pathology when performed in the office and billed by the physician (copayment does not apply)

PREFERRED PROVIDER BENEFITS: $20 copayment per visit; 100% to a maximum of $200 per visit, then 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

SCHEDULE OF BENEFITS (continued)

PHYSICIAN SERVICES

- **Hospital** visits
- Anesthesiologist
- Surgeon
- Assistant Surgeon allowed at 20% of the **Covered Expense** for the **Surgery**

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

DIAGNOSTIC RADIOLOGY, LABORATORY AND PATHOLOGY (NOT PERFORMED IN THE OFFICE)

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

EMERGENCY CARE

- Emergency Room

PREFERRED PROVIDER BENEFITS: $75 copayment per visit (waived if admitted), then 90% to **Out-of-Pocket Limit**

NON-PREFERRED PROVIDER BENEFITS: $75 copayment per visit (waived if admitted), then 90% to **Out-of-Pocket Limit**

- Emergency Room visit by the physician

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

PHYSICAL MEDICINE/THERAPY

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

SCHEDULE OF BENEFITS (continued)

DURABLE MEDICAL EQUIPMENT

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

AMBULANCE

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

PRENATAL CARE
Maximum benefit is $200 per pregnancy for any female **Covered Person**

PREFERRED PROVIDER BENEFITS: 100% (**Deductible** does not apply)

NON-PREFERRED PROVIDER BENEFITS: 100% (**Deductible** does not apply)

COLORECTAL CANCER SCREENING

PREFERRED PROVIDER BENEFITS: 100% (**Deductible** does not apply)

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** (**Deductible** does not apply)

ROUTINE MAMMOGRAM, PAP SMEAR AND PSA TEST
Does not include related office visits

PREFERRED PROVIDER BENEFITS: 100% (**Deductible** does not apply)

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** (**Deductible** does not apply)

IMMUNIZATIONS TO AGE 18
Does not include related office visits

PREFERRED PROVIDER BENEFITS: 100% (**Deductible** does not apply)

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** (**Deductible** does not apply)

SCHEDULE OF BENEFITS (continued)

HOSPICE CARE

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

HOME HEALTH CARE
Must be in lieu of a **Hospital Confinement** or **Skilled Nursing Facility**
100 **Home Health Care Visits** per calendar year

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

SKILLED NURSING FACILITY
30 days per calendar year

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

NORMAL PREGNANCY:

Covered as any other **Sickness** for any female **Covered Person.**

SCHEDULE OF BENEFITS - MENTAL HEALTH

ALL **SERVICES** ARE SUBJECT TO ALL THE TERMS AND PROVISIONS, LIMITATIONS AND EXCLUSIONS OF THE POLICY

SUMMARY OF SERVICES

MENTAL DISORDERS

INPATIENT CARE
Limited to 10 days per calendar year maximum benefit

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

SUMMARY OF SERVICES

MENTAL DISORDERS

OUTPATIENT CARE AND OFFICE THERAPY
Limited to 15 visits per calendar year maximum benefit

PREFERRED PROVIDER BENEFITS: 50% after **Deductible** (Does not apply to **Your Out-of-Pocket limit)**

NON-PREFERRED PROVIDER BENEFITS: 50% after **Deductible** (Does not apply to **Your Out-of-Pocket limit)**

SUBSTANCE ABUSE (CHEMICAL AND ALCOHOL DEPENDENCE)

Limited to the calendar year maximum* and lifetime maximum of the Policy

HOSPITAL OUTPATIENT AND INTERMEDIATE CARE*

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

PHYSICIAN OUTPATIENT AND INTERMEDIATE CARE*

PREFERRED PROVIDER BENEFITS: 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

SCHEDULE OF BENEFITS - MENTAL HEALTH (continued)

OFFICE VISITS AND HOME VISITS

PREFERRED PROVIDER BENEFITS: $20 copayment per visit, 100% to a maximum of $200 per visit, then 90% to **Out-of-Pocket Limit** after **Deductible**

NON-PREFERRED PROVIDER BENEFITS: 70% to **Out-of-Pocket Limit** after **Deductible**

* Outpatient and intermediate care and office and home visits combined will not exceed the calendar year maximum. The calendar year maximum benefit is adjusted annually in accordance with the U.S. Consumer Price Index. Contact **Us** for the current calendar year maximum benefit payable by the Policy.

SCHEDULE OF BENEFITS
PRE-EXISTING CONDITION EXCLUSION

If **You** received medical attention (medical attention means care, advice, examination, treatment, services, medication, procedures, test, consultation, referral or diagnosis) for a condition during the 6 months prior to **Your Enrollment Date**, such condition will be subject to the **Pre-Existing Condition** exclusion.

The **Pre-Existing Condition** exclusion will not exceed 6 months from **Your Enrollment Date**.

A diagnosis is not required for a physical or mental condition to be a **Pre-Existing Condition**. Genetic information, in itself, is not considered a condition. Pregnancy, when covered under **Your** Plan, is not subject to the **Pre-Existing Condition** exclusion.

The **Pre-Existing Condition** exclusion will NOT apply to:

- A newborn child who is covered on his/her date of birth; or
- A legally adopted child, including a child placed with the **Employee** for the purpose of adoption, if coverage is effective on the child's eligibility date.

PORTABILITY OF CREDITABLE COVERAGE

You are eligible for Portability of **Creditable Coverage** if **Your** coverage was continuous without a break of more than 63 days between the termination of coverage under **Creditable Coverage** and the **Enrollment Date** under this Policy.

The **Pre-Existing Condition** exclusion period will be reduced by the number of days of coverage that **You** had under the **Creditable Coverage**, if **Your** coverage was continuous to a date NOT more than 63 days prior to the **Enrollment Date** under this Policy.

If **You** are a **Late Applicant**, the **Pre-Existing Condition** exclusion period will be reduced by the number of days of coverage that **You** had under the **Creditable Coverage**, if **Your** coverage was continuous to a date NOT more than 63 days prior to the date **We** receive the enrollment form.

If on a particular day **You** have **Creditable Coverage** from more than one source, all the **Creditable Coverage** on that day will be counted as one day. Any waiting period for a Plan or Policy is counted toward determining whether there has been a 63-day break in coverage.

NOTICE:

You must submit to **Us** certification of **Creditable Coverage** from **Your** prior plan(s). Upon request and authorization from **You**, **We** can contact **Your** prior carrier(s) for **Your Creditable Coverage** certification.

DEFINITIONS

The following are definitions of terms as they are used in this Certificate. Defined terms are printed in bold face type wherever found in this Certificate.

ACTIVE STATUS

Active Status means the **Employee** is performing all of his/ her customary duties whether performed at the **Employer's** business establishment or another location when required to travel on the job:

1. On a regular full-time basis;
2. For the number of hours per week shown on the Employer Group Application;
3. For 48 weeks a year; and
4. Is maintaining a bona fide employee-employer relationship with the sponsor of this group Policy on a regular basis.

Each day of a regular vacation and any regular non-working holiday is deemed **Active Status**, if he or she was in **Active Status** on his or her last regular working day prior to the vacation or holiday. **You** are deemed to be in **Active Status**, if **Your** absence from work is due to a **Sickness** or **Bodily Injury**, provided **You** otherwise meet the definition of **Employee.**

BODILY INJURY

Bodily Injury means injury due directly to an accident. Muscle strain due to athletic or physical activity is considered a **Sickness**.

COINSURANCE

Coinsurance means the percentage of the **Covered Expense** that **You** are responsible for until **You** reach the **Out-of-Pocket Limit** as shown on **Your** Schedule of Benefits.

COMPLICATIONS OF PREGNANCY

Complications of Pregnancy means:

1. Conditions with diagnoses which are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis; nephrosis; cardiac decompensation; hyperemesis gravidarum; puerperal infection; toxemia; eclampsia; and missed abortion;
2. A nonelective cesarean section;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

DEFINITIONS (continued)

Complications of Pregnancy does NOT mean:

1. False labor;
2. Occasional spotting;
3. Rest prescribed during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct **Complications of Pregnancy**; or
5. An elective cesarean section.

CONFINEMENT

Confinement means being a resident patient in a **Hospital** or **Qualified Treatment Facility** for at least 15 consecutive hours. **Confinement** does not mean detainment in **Observation Status.**

Successive **Confinements** are considered to be one **Confinement** if:

1. Due to the same **Bodily Injury** or **Sickness**; and
2. Separated by fewer than 30 consecutive days when **You** are not confined.

COSMETIC SURGERY

Cosmetic Surgery means **Surgery** performed to reshape normal structures of the body in order to improve **Your** appearance and self-esteem.

COVERED EXPENSE

Covered Expense means:

1. A **Medically Necessary** expense;
2. For the benefits stated in this Certificate; and
3. An **Expense Incurred** when **You** are insured for that benefit under this Policy on the date that the **Service** is rendered.

Covered Expense is payable on a **Maximum Allowable Fee** basis and as shown on **Your** Schedule of Benefits, up to any maximum benefit.

DEFINITIONS (continued)

COVERED PERSON

Covered Person means the **Employee** and/or the **Employee's** covered **Dependents.**

CREDITABLE COVERAGE

Creditable Coverage means coverage under the following:

1. A Group health plan including governmental or church plans;
2. Individual or group health insurance;
3. Medicare (Part A or Part B);
4. Medicaid;
5. Military-sponsored health care;
6. A program of Indian Health Service or medical care under a tribal organization;
7. A State High Risk Health Benefit Pool;
8. The Illinois Children's Health Insurance Program;
9. Federal Employee Health Benefit Plan (FEHBP);
10. A public Health Plan;
11. A Health Plan run by the Peace Corps Act; or
12. Foreign health care.

Creditable Coverage does not include coverage under accident only, disability, liability, credit-only, workers' compensation or similar insurance, automobile medical payment insurance, coverage for on-site medical clinics or other similar insurance. It also does not include a health Flexible Spending Account (FSA), if it meets the Internal Revenue Service Definition of a health FSA, and **You** have other coverage available under a group health plan; and **Your** maximum benefit payable under the FSA does not exceed two times **Your** salary election. If **Your** maximum benefit payable under the FSA is greater than two times **Your** salary election, it must not exceed more than $500 plus **Your** salary election.

DEFINITIONS (continued)

CUSTODIAL CARE

Custodial Care means **Services** given to **You** if:

1. **You** need **Services** including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or

2. The **Services You** require are not likely to improve **Your** condition.

Services may still be considered **Custodial Care** by **Us** even if:

1. **You** are under the care of a physician; or

2. The physician prescribed **Services** are to support or maintain **Your** condition; or

3. **Services** are being provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.); or

4. **Services** involve the use of skills which can be taught to a lay person; or

5. **You** do not require the technical skills of a licensed nurse at all times.

DEDUCTIBLE

1. **Individual Deductible** means the amount of **Covered Expense** that a **Covered Person** is responsible to pay per calendar year before any benefits are payable by **Us** with respect to that **Covered Person.**

2. **Maximum Family Deductible** means the amount of **Individual Deductibles** that a family must pay. Once met, any remaining **Individual Deductibles** will be waived for that calendar year.

DENTAL INJURY

Dental Injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. It does not include chewing injuries.

DEPENDENT

Dependent means a covered **Employee's:**

1. Legally recognized spouse; or

2. Unmarried natural blood related child, step-child, or legally adopted child whose age is less than the limiting age. Adopted child includes a child who is in the custody of the **Employee**, pursuant to an interim court order of adoption vesting temporary care of the child to **You**, regardless of whether a final order granting adoption is ultimately issued.

DEFINITIONS (continued)

Under no circumstances shall **Dependent** mean a grandchild, great grandchild, foster child or **Emancipated Minor** unless the child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age for each **Dependent** child is:

1. The child's 19th birthday; or

2. For medical coverage only, the child's 25th birthday if such child is in regular full-time attendance at an accredited secondary school, college or university. The **Dependent** child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A **Dependent** child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

You must furnish satisfactory proof to **Us** upon **Our** request that the above conditions continuously exist. If satisfactory proof is not submitted to **Us**, the child's coverage will not continue beyond the last date of eligibility.

A covered **Dependent** child who becomes an employee eligible for other group coverage through employment is no longer eligible as a **Dependent** for coverage under this Policy.

A covered **Dependent** child who attains the limiting age WHILE INSURED under this Policy remains eligible for Medical Expense Benefits if:

1. Mentally retarded or permanently physically handicapped;

2. Incapable of self-sustaining employment;

3. The child meets all of the qualifications of a **Dependent** as determined by the Internal Revenue Service;

4. Declared on and legally qualified as a **Dependent** on the **Employee's** federal personal income tax return filed for each year of coverage; and

5. Unmarried.

You must furnish satisfactory proof to **Us** upon **Our** request that the above conditions continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, **We** may not request such proof more often than annually. If satisfactory proof is not submitted to **Us,** the child's coverage will not continue beyond the last date of eligibility.

DEFINITIONS (continued)

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose;
3. Not be generally useful to a person except for the treatment of a **Bodily Injury** or **Sickness**; and
4. Be **Medically Necessary**.

EMANCIPATED MINOR

Emancipated Minor means a child who has not yet attained full legal age, but who has been declared by a court to be emancipated.

EMERGENCY CARE

Emergency Care means **Services** provided for a **Bodily Injury** or **Sickness** manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in:

1. Placing **Your** health, or if **You** are pregnant, **Your** or **Your** unborn child's health, in serious jeopardy:
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Care does not mean **Services** for the convenience of the **Covered Person** or the provider of treatment or **Services.**

EMPLOYEE

Employee means a person who is permanently employed, in an **Active Status** at the **Employer's** place of business, and paid a salary or a wage by the **Employer** that meets the minimum wage requirements of **Your** state or federal minimum wage law. **Employee** also includes a sole proprietor, partner or corporate officer where:

1. The **Employer** is a sole proprietorship, partnership or corporation; and
2. The sole proprietor, partner or corporate officer is actively performing activities relating to the business, and gains their livelihood from the sole proprietorship, partnership or corporation and is in an **Active Status** at the **Employer's** place of business.

DEFINITIONS (continued)

EMPLOYER

Employer means the sponsor of this Group Insurance Plan, or any subsidiary described in the Employer Group Application. To be covered by this Plan, an **Employer** must meet the definition of **Employee**.

ENROLLMENT DATE

If **You** are NOT a Late Applicant, **Your Enrollment Date** is the earlier of the following:

1. The first day **Your** coverage is effective under this Policy; or
2. The first day of the waiting period for enrollment, if any waiting period is applicable.

Your Enrollment Date is the first day **Your** coverage is effective under this Policy, if:

1. **You** are a Late Applicant; or
2. **You** are enrolled on a **Special Enrollment Date**.

EXPENSE INCURRED

Expense Incurred means the **Maximum Allowable Fee** charged for **Services** which are **Medically Necessary** to treat the condition. The date a **Service** is rendered is the **Expense Incurred** date.

EXPERIMENTAL, INVESTIGATIONAL or for RESEARCH PURPOSES

A **Service** is **Experimental, Investigational** or for **Research Purposes** if **We** determine:

1. The **Service** cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the **Service** is furnished; or
2. The **Service** or **Your** informed consent document utilized with the **Service** was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the **Service** is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the **Service** is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
5. Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same **Service**; or the written informed consent used by the treating facility or by another facility studying substantially the same **Service**.

DEFINITIONS (continued)

FAMILY MEMBER

Family Member means **You** or **Your** spouse, or **You** or **Your** spouse's child, brother, sister, or parent.

FREE-STANDING SURGICAL FACILITY

A **Free-Standing Surgical Facility** means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide services or accommodations for patients to stay overnight.

HEALTH INSURANCE COVERAGE

Health Insurance Coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or HMO contract offered by a Health Insurance Issuer; Health Insurance Issuer means an Insurance Company, Insurance Service, Insurance Organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance.

HOME HEALTH CARE PROVIDER

Home Health Care Provider means an agency licensed by the proper authority as a Home Health Agency, or Medicare Approved as a Home Health Agency and provides 24-hour-a-day, 7-day-a-week **Service**, supervised by a **Qualified Practitioner**.

HOME HEALTH CARE PLAN

Home Health Care Plan means a plan of health care established with a **Home Health Care Provider**. The **Home Health Care Plan** consists of:

1. Care by or under the supervision of a registered nurse (R.N.); or
2. Physical, speech, occupational, respiratory therapy, or
3. Medical appliances and equipment, if such supplies would have been covered if **You** were **Hospital** confined.

A **Qualified Practitioner** must:

1. Review and approve the **Home Health Care Plan;** and
2. Certify and verify the **Home Health Care Plan** is required in lieu of continued **Hospital, Qualified Treatment Facility** or **Skilled Nursing Facility Confinement**; and
3. Not be related to the **Home Health Care Provider** by ownership or contract.

DEFINITIONS (continued)

HOME HEALTH CARE VISIT

Home **Health Care Visit** means **Services** provided by any one **Qualified Practitioner** for four (4) consecutive hours or any portion thereof.

HOSPICE CARE AGENCY

Hospice Care Agency means an agency which:

1. Has the primary purpose of providing hospice services to **Hospice Patients;**
2. Is licensed and operated according to the laws of the state in which it is located; and
3. Meets all of these requirements:
   - A. Has obtained any required certificate of need;
   - B. Provides 24-hour-a-day, 7-day-a-week **Service**, supervised by a qualified physician;
   - C. Has a full-time administrator;
   - D. Keeps written records of **Services** provided to each patient;
   - E. Has a coordinator who:
     - i). Is an R.N.;
     - ii). Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
   - F. Has a licensed social service coordinator.

HOSPICE CARE PROGRAM

Hospice Care Program means a written plan of hospice care which:

1. Is established and reviewed by:
   - A. The **Qualified Practitioner** attending the person; and
   - B. The Hospice Care Agency; and
2. Provides:
   - A. Palliative and supportive care to **Hospice Patients;**
   - B. Supportive care to the families of **Hospice Patients;**
   - C. An assessment of the **Hospice Patient's** medical and social needs; and
   - D. A description of the care to meet those needs.

DEFINITIONS (continued)

HOSPICE FACILITY

Hospice Facility means a licensed facility or part of a facility which:

1. Principally provides hospice care;
2. Keeps medical records of each patient;
3. Has an ongoing quality assurance program;
4. Has a physician on call at all times;
5. Provides 24-hour-a-day skilled nursing **Services** under the direction of an R.N.; and
6. Has a full-time administrator.

HOSPICE PATIENT

Hospice Patient means a terminally ill person with six months or less to live.

HOSPITAL

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing **Services**;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical **Services** with an institution having a valid license to provide such surgical **Services**; or
7. Is a lawfully operated **Qualified Treatment Facility** certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does NOT include an institution which is principally a rest home, nursing home, convalescent home or home for the aged. **Hospital** does NOT include a place principally for the treatment of alcohol or chemical dependency or **Mental Disorders**.

DEFINITIONS (continued)

MAINTENANCE CARE

Maintenance Care means any **Service** or activity which seeks to prevent disease, prolong life or promote health of an asymptomatic **Covered Person** who has reached the maximum level of improvement and whose condition is resolved or stable.

MAXIMUM ALLOWABLE FEE

Maximum Allowable Fee for a **Covered Expense** is the lesser of:

1. The fee charged by the provider for the **Services**;
2. The fee that has been negotiated with the provider whether directly or through one or more intermediary, or shared savings contracts for the **Services**;
3. The fee established by comparing rates from one or more regional or national databases or schedules for the same or similar **Services** from a geographic area determined by **Us**;
4. The fee based on rates negotiated with one or more participating providers in a geographic area determined by **Us** for the same or similar **Services**;
5. The fee equal to the provider's costs for providing the same or similar **Services** as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
6. The fee based on a percentage of the fee Medicare allows for the same or similar **Services** provided in the same geographic area.

NOTE: The bill **You** receive for **Services** from nonparticipating providers may be significantly higher than the **Maximum Allowable Fee**. In addition to **Your** Out-of-Pocket **Deductibles** and **Coinsurance**, **You** are responsible for the difference between the **Maximum Allowable Fee** and the amount the provider bills **You** for the **Services**. Any amount **You** pay to the provider in excess of the **Maximum Allowable Fee** will not apply to **Your Out-of-Pocket Limit** or **Deductible**.

MEDICALLY NECESSARY

Medically Necessary means the extent of **Services** required to diagnose or treat a **Bodily Injury** or **Sickness** which is known to be safe and effective by the majority of **Qualified Practitioners** who are licensed to diagnose or treat that **Bodily Injury** or **Sickness**. Such **Services** must be:

1. Performed in the least costly setting required by **Your** condition;
2. Not provided primarily for the convenience of **You** or the **Qualified Practitioner**;
3. Consistent with **Your** symptoms or diagnosis of the **Sickness** or **Bodily Injury** under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for **Your** symptoms, diagnosis, or **Sickness** or **Bodily Injury**; and
5. Substantiated by the records and documentation maintained by the provider of **Service**.

DEFINITIONS (continued)

MENTAL DISORDER

Mental Disorder means mental, nervous, or emotional diseases or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder.

MORBID OBESITY

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a healthcare practitioner as of the date of service of:

- 40 kilograms or greater per meter squared (kg/m^2); or
- 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

NETWORK

Network means a group of providers who have entered into a contract with **Us** to provide **Services** at negotiated rates.

OBSERVATION STATUS

Observation Status means a stay in a **Hospital** or **Qualified Treatment Facility** not to exceed 24 hours if:

1. **You** have not been admitted as an inpatient;

2. **You** are physically detained in an emergency room, treatment room, observation room or other such area; or

3. **You** are being observed to determine whether an inpatient **Confinement** will be required.

OUT-OF-POCKET LIMIT

1. **Individual Out-Of-Pocket Limit** means the amount of **Deductible** and **Coinsurance** that a **Covered Person** must pay before **We** will pay **Covered Expense** at 100%.

2. **Family Out-of-Pocket Limit** means the amount of **Deductible** and **Coinsurance** that **You** and **Your** covered **Dependents** must pay before **We** will pay **Covered Expense** at 100%.

DEFINITIONS (continued)

PREADMISSION TESTING

Preadmission Testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a **Hospital**. The tests must be for the same **Bodily Injury** or **Sickness** causing **You** to be **Hospital** confined. The tests must be accepted by the **Hospital** in place of like tests made during **Confinement. Preadmission Testing** does NOT mean tests for routine physical check-ups.

PREAUTHORIZATION

Preauthorization means that prior approval is given by **Us. Preauthorization** review will determine if the proposed **Service** is a **Covered Expense. Preauthorization** is subject to the terms and provisions of this Policy.

PRE-EXISTING CONDITION

Pre-Existing Condition means a physical or mental condition for which **You** have received medical attention (medical attention means care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis) during the six (6) months prior to **Your Enrollment Date.**

The time period for **Pre-Existing Condition** exclusion under this Policy is described on the Schedule of Benefits.

PRENATAL CARE

Prenatal Care means **Covered Expense** for obstetrical care received by any female **Covered Person** from a **Qualified Practitioner.**

PRESERVICE NOTIFICATION

Preservice Notification means notification to **Us** by **You** or a **Qualified Practitioner** of a proposed **Service.**

PRESERVICE REVIEW

Preservice Review means a review by **Us,** at **Our** option, of a proposed **Service** in a **Hospital** or **Qualified Treatment Facility** to determine:

1. If the proposed **Service** or **Confinement** is **Medically Necessary**; and

2. If the use of alternative care is appropriate, such as:

   A. Skilled Nursing Facilities;

   B. Home health care services;

DEFINITIONS (continued)

C. Inpatient or outpatient **Hospice Care Programs**;

D. Partial hospitalization;

E. Intensive outpatient programs; or

F. Any other alternatives.

QUALIFIED PRACTITIONER

Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a **Bodily Injury** or **Sickness,** and who provides **Services** within the scope of that license. A **Qualified Practitioner's Services** are not covered if the practitioner resides in **Your** home or is **Your Family Member**.

QUALIFIED TREATMENT FACILITY

Qualified Treatment Facility means only a facility, institution, or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

SERVICES

Services means procedures, **Surgeries,** consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, or technologies.

SERIOUS MENTAL ILLNESS

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) IV-TM:

- Schizophrenia,
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.
- Panic disorder;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset).

DEFINITIONS (continued)

SICKNESS

Sickness means a disturbance in function or structure of **Your** body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of **Your** body.

SKILLED NURSING FACILITY

Skilled Nursing Facility means only an institution licensed as a **Skilled Nursing Facility** and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;
2. A **Qualified Practitioner's** services available at all times;
3. 24-hour-a-day skilled nursing services under the full-time supervision of a physician or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from illness or injury; and
6. A utilization review plan in effect.

A **Skilled Nursing Facility** is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of chemical or alcohol dependence.

SMALL EMPLOYER

Small Employer means an **Employer** who employed an average of two (2) but not more than fifty (50) **Employees** on business days during the preceding calendar year and who employs at least two (2) **Employees** on the first day of the plan year, unless otherwise provided under State law. All entities that are affiliated or that are eligible to file combined tax return are considered one **Employer**.

SOUND NATURAL TOOTH

Sound Natural Tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than whole natural tooth.

DEFINITIONS (continued)

SPECIAL ENROLLMENT DATE

Special Enrollment Date means:

1. The date of change in family status after the initial Eligibility Date, as follows:

   A. Date of marriage;

   B. Date of birth of a natural born child; or

   C. Date of adoption of a child or date of placement of a child with the **Employee** for the purpose of adoption; or

2. The date of termination of coverage under a group health plan or other **Health Insurance Coverage**, as specified under the Special Enrollment provision.

SURGERY

Surgery means excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

TOTAL DISABILITY

Total Disability or **Totally Disabled** means, for the **Employee** or **Employee's** employed covered **Dependent** spouse, that during the first 24 months of disability that person is at all times prevented by **Bodily Injury** or **Sickness** from performing each and every material duty of his or her respective job or occupation.

After the first 24 months, **Total Disability** or **Totally Disabled** means that person is at all times prevented by **Bodily Injury** or **Sickness** from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training or experience.

For any **Covered Dependent** who is not employed, **Total Disability** means a disability preventing that person from performing the usual and customary activities of a person in good health and of the same age and gender.

A **Totally Disabled** person also may not engage in ANY job or occupation for wage or profit.

WE, US, and OUR

We, Us, and **Our** means the Insurance Company as shown on the cover page of this Certificate.

YOU and YOUR

You and **Your** means any **Covered Person**.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBILITY DATE

EMPLOYEE ELIGIBILITY DATE

The **Employee** is eligible for coverage on the date:

1. The eligibility requirements stated in the Employer Group Application are satisfied; and
2. The **Employee** is in an **Active Status.**

DEPENDENT ELIGIBILITY DATE

Each **Dependent** is eligible for coverage on:

1. The date the **Employee** is eligible for coverage, if he or she has **Dependents** who may be covered on that date;
2. The date of the **Employee's** marriage for any **Dependents** (spouse or child) acquired on that date;
3. The date of birth of the **Employee's** natural-born child;
4. The date the child is placed in the **Employee's** home for the purpose of adoption by the **Employee**; or
5. The date specified in the court or administrative order, which requires the **Employee** to provide coverage for a child or spouse as specified in such order, if **You** are eligible for **Dependent** coverage.

The **Employee** may cover his or her **Dependents** ONLY if the **Employee** is also covered.

A **Dependent** child who becomes eligible for other group coverage through any employment is no longer eligible for group coverage under this Policy. If a **Dependent** child becomes an **Employee** of the participating **Employer**, he or she is no longer eligible as a **Dependent** and must make application as an eligible **Employee.**

ENROLLMENT

EMPLOYEE ENROLLMENT

The **Employee** must enroll on forms furnished and accepted by **Us.** Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Employee** to provide evidence of health status whenever an enrollment form is submitted.

If **You** enroll more than 31 days after **Your** eligibility date or more than 31 days after **Your Special Enrollment Date**, **You** are a Late Applicant.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

DEPENDENT ENROLLMENT

Check with the **Employer** immediately on how to enroll for **Dependent** coverage. The **Employee** must enroll for **Dependent** coverage and enroll additional **Dependents** on forms furnished and accepted by **Us.**

Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Dependent** to provide evidence of health status whenever an enrollment form is submitted.

A **Dependent** enrolled more than 31 days after the **Dependent's** eligibility date or the **Special Enrollment Date** will be a Late Applicant.

NEWBORN DEPENDENT ENROLLMENT

An **Employee** who already has **Dependent** child coverage in force PRIOR to the newborn's date of birth is not required to complete an enrollment form for the newborn child.

An **Employee** who does not have **Dependent** child coverage must complete an enrollment form for the newborn **Dependent.** This form is available from **Your Employer** or from **Us.**

SPECIAL ENROLLMENT

LOSS OF OTHER COVERAGE

If **You** are an **Employee** or **Dependent** who was previously eligible for coverage under this Plan and had waived coverage, **You** may be eligible for the Special Enrollment provision. **You** will not be considered a Late Applicant, if the following applies:

1. **You** declined enrollment under this Plan at the time of initial enrollment because:

   A. **You** were covered under a group health plan or other **Health Insurance Coverage** at the time of eligibility; and **Your** coverage terminated as a result of:

      i) Termination of employment or eligibility;

      ii) Reduction in number of hours of employment;

      iii) Divorce, legal separation or death of a spouse; or

      iv) Termination of **Your Employer's** contribution for the coverage; or

   B. **You** had COBRA continuation coverage under another Plan at the time of eligibility and such coverage has since been exhausted; and

   C. **You** stated, at the time of the initial enrollment, that coverage under the group health plan or other **Health Insurance Coverage** or COBRA continuation was **Your** reason for declining enrollment; and

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

D. **You** apply for coverage within 31 days after termination of coverage under the group health plan or other **Health Insurance Coverage** or COBRA; or

2. **You** were covered under an alternate Plan provided by the **Employer** and **You** are replacing coverage with this Plan.

DEPENDENT SPECIAL ENROLLMENT PERIOD

The Special Enrollment Period is a 31 day period from the **Special Enrollment Date**.

If **Dependent** coverage is available under the **Employer**'s group Plan or added to the Plan, an **Employee** who is a **Covered Person** can enroll eligible **Dependents** during the Special Enrollment Period. An **Employee,** who is otherwise eligible for coverage and had waived coverage under this Plan when eligible, can enroll himself/ herself and eligible **Dependents** during the Special Enrollment Period. The **Employee** or **Dependent** enrolling within 31 days from the **Special Enrollment Date** will not be considered a Late Applicant.

EMPLOYEE EFFECTIVE DATE

The **Employee's** Effective Date Provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the probationary period, or the **Special Enrollment Date.**

Effective date is the first date of coverage under this Plan.

If **You** enroll more than 31 days after **Your** eligibility date or the **Special Enrollment Date, You** are a Late Applicant. The effective date of coverage will be the first of the month following the receipt of the enrollment form.

EMPLOYEE DELAYED EFFECTIVE DATE

If the **Employee** is not in **Active Status** on the eligibility date, coverage will be effective the day after the **Employee** returns to **Active Status.** The **Employer** must notify **Us** in writing of the **Employee's** return to **Active Status.**

DEPENDENT EFFECTIVE DATE

1. If **We** receive the enrollment form on, prior to or within 31 days of the **Dependent's** eligibility date that **Dependent** is covered on the date he or she is eligible:

2. If **We** receive the enrollment form on, prior to or within 31 days of the **Dependent's Special Enrollment Date**, that **Dependent's** coverage is effective on the **Special Enrollment Date.**

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

3. If **We** receive the enrollment form more than 31 days after the **Dependent's** eligibility date or the **Special Enrollment Date**, that **Dependent** is considered a Late Applicant. The effective date of coverage will be the first of the month following the receipt of the enrollment form.

However, NO **Dependent's** effective date will be prior to the **Employee's** effective date of coverage.

NEWBORN DEPENDENT EFFECTIVE DATE

A newborn **Dependent's** effective date is determined as follows:

1. If **We** receive the enrollment form on, prior to or within 31 days of the newborn's date of birth, **Dependent** coverage is effective on the newborn's date of birth.

2. If **We** receive the enrollment form more than 31 days after the newborn's date of birth, the newborn is considered a Late Applicant. The newborn's effective date of coverage will be the first of the month following the receipt of the enrollment form.

BENEFIT CHANGES

Benefit changes will become effective on the date specified by **Us**, if the **Employee** is in **Active Status** on that date. Otherwise, the change will be effective on the day the **Employee** returns to **Active Status**.

RETIRED EMPLOYEE COVERAGE

RETIRED EMPLOYEE ELIGIBILITY DATE

Retired **Employees** are an eligible class of **Employees** if requested on the Employer Group Application and if approved by **Us**. An **Employee** who retires WHILE INSURED under this Policy is considered eligible for Retired **Employee** medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

RETIRED EMPLOYEE ENROLLMENT

Notification of the **Employee's** retirement must be submitted to **Us** by the **Employer** within 31 days of the date of retirement. If **We** receive the notification more than 31 days after the date of retirement, **You** will be considered a Late Applicant.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

RETIRED EMPLOYEE EFFECTIVE DATE

The effective date of coverage for an eligible retired **Employee** is the date of retirement for an **Employee** who retires AFTER the date **We** approve the **Employer's** request for a retiree classification, provided **We** receive notice of the retirement within 31 days. If **We** receive notice more than 31 days after retirement, the effective date of coverage will be the date **We** specify.

RETIRED EMPLOYEE'S BENEFIT CHANGES

Additional or increased insurance or a decrease in insurance will become effective on the approved date of change.

TERMINATION OF COVERAGE

Termination of Coverage may be immediate or at the end of the period which was selected by **Your Employer** on the Employer Group Application.

Insurance terminates on the earliest of the following:

1. The date this Group Policy terminates;
2. The end of the period for which required premium was due **Us** and not received by **Us**;
3. The date the **Employer's** participation under this Policy terminates;
4. For the **Employee**, the date he or she terminates employment with the **Employer**;
5. For an **Employee**, the date he or she no longer qualifies as an **Employee**;
6. The date **You** fail to be in an eligible class of persons as provided in the Insurance Classifications as stated in the Employer Group Application;
7. The date **You** enter full-time military, naval or air service;
8. The date the **Employee** retires, except if the Employer Group Application provides coverage for a retiree class of **Employees** and the retiree is in an eligible class of retirees, selected by the **Employer**, and **We** are notified by the **Employer**;
9. The date the **Employee** requests termination of insurance to be effective for the **Employee** or **Dependents**;
10. For a **Dependent**, the date the **Employee's** insurance terminates;
11. For a **Dependent**, the date he or she no longer qualifies as a **Dependent**; or
12. For any benefit, the date the benefit is deleted from this Policy.

YOU AND THE **EMPLOYER** ARE RESPONSIBLE TO ADVISE **US** OF ANY CHANGES IN ELIGIBILITY INCLUDING THE LACK OF ELIGIBILITY OF ANY **COVERED PERSON**. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY REGARDLESS OF THE LACK OF NOTICE TO **US**.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If the **Employer** continues to pay required premiums and continues participation under this Policy, **Your** coverage, other than Short Term Disability benefits, if any, will remain in force for:

1. No longer than three consecutive months if the **Employee** is:
   A. Temporarily laid-off;
   B. In part-time status; or

C. On an **Employer** approved leave of absence.

2. No longer than 12 consecutive months if the **Employee** is **Totally Disabled.**

If the **Employee** becomes **Totally Disabled** and wishes to apply for Waiver of Premium, **We** must receive premium for **Employee** Term Life Coverage for the six consecutive month period while the **Employee** is covered under the Special Provisions for Not Being in Active Status. All premium must be submitted to **Us** through the **Employer**.

If this coverage terminates, the **Employee** may exercise the rights under any applicable Continuation of Medical Benefits provision, or the Medical or Life Conversion Privilege described in this Certificate. If the **Employee** utilizes the Conversion Privilege, he or she thereby waives the right to continue coverage. If the **Employee** returns to an **Active Status**, he or she will be considered a new **Employee** and must re-enroll for **Employee** Coverage.

CONTINUATION FOR LOSS OF EMPLOYMENT

If **Your** medical coverage under the Policy terminates due to loss of employment **You** may continue medical coverage for **You** and **Your** covered **Dependents** if:

1. **You** were covered under the Policy for at least three consecutive months immediately prior to termination;

2. **You** are not eligible for Medicare or other group coverage; and

You and **Your Dependents** are NOT eligible for continuation of medical coverage if **You** were discharged from **Your** employment due to commission of a felony or a theft in connection with **Your** work and for which the **Employer** was in no way responsible; provided that **You** have admitted to commission of the felony or theft or have been convicted or received an order of supervision by a court of competent jurisdiction for such act.

ENROLLMENT

The **Employer** will notify **You** in writing of **Your** right to continue coverage. If **You** elect to continue coverage **You** must notify the **Employer** in writing within ten days following:

1. The date **Your** coverage would otherwise terminate; or

2. The date **You** received written notification of **Your** right to continue coverage.

In no event will **You** be eligible to elect continuation of coverage more than 60 days after the date **Your** coverage would otherwise terminate.

If **You** elect to continue coverage **You** must pay the total monthly premium in advance to the **Employer**. The premium for continuing **Your** coverage will be the rate which would have been applicable to the **Employer** for **Your** group coverage during the continuation period.

TERMINATION OF COVERAGE (continued)

If **You** do not choose to continue **Your** group medical coverage, or if **You** do and it terminates, **You** have the right to exercise the Medical Conversion Privilege described in the Certificate. If **You** do not continue coverage and utilize the Conversion Privilege **You** thereby waive the right to continue coverage. The Medical Conversion Privilege is available to **Your** covered **Dependents** while **You** are insured under this continuation privilege.

TERMINATION

Medical coverage may be continued under this right until the earliest of the following:

1. 9 months after the date **Your** coverage would otherwise have terminated;

2. The end of any month for which **You** fail to make timely payment of premium;

3. The date this Policy terminates or the date the **Employer** terminates participation under this Policy. If the Group Policy is replaced, coverage will continue under the new policy;

4. The date **You** become eligible for Medicare or other group coverage; or

5. For **Your Dependent**, the date he or she no longer meets the definition of **Dependent.**

If the **Employee** returns to **Active Status** while insured under this continuation privilege, he or she must re-enroll for **Employee** Coverage.

CONTINUATION FOR MUNICIPAL EMPLOYEES

If **Your** medical coverage under the Policy terminates due to retirement or disability, **You** may continue medical coverage for **You** and **Your** covered **Dependents** if:

1. **You** are a participant in the Illinois Municipal Retirement Fund; and

2. **You** and **Your** covered **Dependents** are insured under the provisions of this group policy on the day immediately preceding the day on which **Your** retirement or disability begins.

DEFINITIONS

"Retirement " or "disability period" of an **Employee** means the period which begins on the day the **Employee** is removed from the municipality payroll because of the occurrence of either of the following events:

1. The **Employee** retires from active service as an **Employee** with an attained age and accumulated creditable service which together qualify the **Employee** for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code; or

2. The **Employee's** disability is established under Article 7 of the Illinois Pension Code.

TERMINATION OF COVERAGE (continued)

ENROLLMENT

Within 15 days of the beginning of the retirement or disability period of any eligible **Employee**, the municipality shall give written notice to **Us**. Within 15 days of receipt of such notice, **We** will give written notice to **You** of **Your** right to continue coverage. **You** must return the election from to **Us** by certified mail, return receipt requested, within 15 days of receiving it.

It is **Your** obligation to pay the monthly premium directly to the municipality for forwarding to **Us**, or to designate on the election form that the premium, or portion thereof, be deducted by the Illinois Municipal Retirement Fund from **Your** monthly pension payment and forwarded to **Us** by the Fund.

TERMINATION

Medical coverage may be continued until the earliest of the following:

1. **Your** reinstatement or reentry into active service as provided for under Article 7 of the Illinois Pension Code; or

2. **Your** exercise of any refund option or acceptance of any separation benefit available under Article 7 of the Illinois Pension Code; or

3. **Your** loss pursuant to Section 7-219 of the Illinois Pension Code of any benefits provided for in Article 7 of that Code; or

4. The **Employee's** death or, if at the time of the **Employee's** death the **Employee** is survived by a spouse who, in that capacity, is entitled to receive a surviving spouse's monthly pension pursuant to Article 7 of the Illinois Pension Code, the death or remarriage of that spouse.

SURVIVORSHIP CONTINUATION

If the **Employee** dies while **Dependent** Coverage is in force, the surviving **Dependent** spouse and **Dependent** children may continue to be insured for medical coverage only. Coverage may continue for 90 days after the death without application, subject to all terms and provisions of this Policy. This 90 day continuation will run concurrently with the following continuation that must be applied for.

CONTINUATION FOR DEPENDENTS DUE TO DIVORCE, DEATH OR RETIREMENT OF THE EMPLOYEE

If **Your** medical coverage under this Policy terminates due to legal annulment, dissolution of marriage, divorce, or the death of the **Employee**, or due to the retirement of the **Employee** (if **You**, the **Dependent** spouse, are age 55 or over at the time of retirement), **You** may continue medical coverage for **You** and **Your** covered **Dependents** if **You**:

1. Notify the **Employer** in writing within 30 days after the date **Your** coverage would otherwise terminate;

2. Elect to continue group medical coverage within 30 days after receipt of written notice of **Your** right to continue coverage; and

3. Pay the total monthly premium in advance to the **Employer**. The premium for continuing **Your** coverage will be the rate which would have been applicable to the **Employer** for **Your** group coverage during the continuation period.

TERMINATION

If the former spouse has not attained the age of 55 at the time the continuation coverage begins, coverage may be continued until the earliest of the following:

1. Two years after the date the continued coverage began;

2. The date the former spouse remarries;

3. The end of any month for which **You** fail to make timely payment of premium;

4. The date coverage would terminate under the terms of the existing Policy if the **Employee** and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce or death of the **Employee** unless the policy is modified or terminated as to all **Employees**;

5. The date this Policy terminates or the date the **Employer** terminates participation under this Policy. If the Group Policy is replaced, coverage will continue under the new Policy;

6. The date the former spouse first becomes an insured employee under any other group health plan after the date of election of continued coverage; or

7. For a **Dependent** child, the date no longer qualified as a **Dependent**.

If the former spouse or retiree's spouse has attained the age of 55 at the time the continuation coverage begins, coverage may be continued until the earliest of the following:

1. The date the former spouse remarries;

2. The end of any month for which **You** fail to make timely payment of premium;

3. The date coverage would terminate, except due to the retirement of an **Employee**, under the terms of the existing Policy if the **Employee** and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce, death or retirement of the **Employee** unless this Policy is modified or terminated as to all **Employees**;

4. The date this Policy terminates or the date the **Employer** terminates participation under this Policy. If the Group Policy is replaced, coverage will continue under the new policy;

5. The date the retiree's spouse or the former spouse first becomes an insured **Employee** under any other group health plan after the date of election of continued coverage;

6. For a **Dependent** child, the date no longer qualified as a **Dependent**; or

7. The date the retiree's spouse or former spouse reached the qualifying age or otherwise becomes eligible for Medicare.

CONTINUATION FOR DEPENDENT CHILDREN

If **Your** (the covered **Dependent** child's) medical coverage under this Policy terminates either due to death of the **Employee** or due to attaining the limiting age as stated in this Certificate, **You** may continue medical coverage if **You** (or the responsible adult acting on **Your** behalf):

1. Notify the **Employer** in writing within 30 days of the date **Your** coverage would otherwise terminate;

2. Elect to continue group medical coverage within 30 days after the receipt of written notice of **Your** right to continue coverage; and

3. Pay the total monthly premium in advance to the **Employer**. The premium for continuing **Your** coverage will be the rate which would have been applicable to the **Employer** for **Your** group coverage during the continuation period.

TERMINATION

Coverage may be continued until the earliest of the following:

1. Two years after the date the continued coverage began;

2. The end of the month for which **You** fail to make timely payment of premium;

3. The date coverage would terminate under the terms of the existing Policy if **You** were still an eligible **Dependent** of the **Employee**; or

4. The date **You** first become an insured employee under any other group health plan after the date of election of continued coverage.

If **You** do not choose to continue **Your** group medical coverage, or if **You** do and it terminates, **You** have the right to exercise the Medical Conversion Privilege described in the Certificate. If **You** do not continue coverage and utilize the Conversion Privilege, **You** thereby waive the right to continue coverage. The Medical Conversion Privilege is available to **Your** covered **Dependents**, in lieu of, or at the termination of eligibility for, the Continuation Privilege, while **You** are insured under this Continuation Privilege.

MEDICAL CONVERSION PRIVILEGE

ELIGIBILITY

Subject to the terms below, if **Your** medical coverage under this Policy terminates, a Medical Conversion Policy is available without medical examination. **You** must have been covered under this Policy for at least 90 days and:

1. **Your** coverage ends because the **Employee's** employment terminated;

2. **You** were the covered **Dependent** spouse or any covered **Dependent** child of an **Employee** whose marriage ended due to legal annulment, dissolution of marriage or divorce;

3. **You** are the surviving covered **Dependent** spouse or covered **Dependent** child, in the event of the **Employee's** death or at the end of any "Survivorship Continuation" as provided by this Policy;

4. **You** have been a covered **Dependent** child but no longer meet the definition of **Dependent** under this Policy; or

5. **Your** group policy discontinues in its entirety or with respect to an insured class.

Only persons covered under this Policy on the date coverage terminates are eligible to be covered under the Conversion Policy.

The Conversion Policy may be issued covering each former **Covered Person** on a separate basis or it may be issued covering all former **Covered Persons** together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be dependent on the **Employee** are eligible to exercise the Conversion Privilege.

This privilege does NOT apply when the **Employer's** participation in this Policy terminates and medical coverage is replaced within 31 days by another group insurance plan.

NOTICE

Election of Conversion coverage would eliminate **Your** federal eligibility for coverage under Illinois Comprehensive Health Insurance Plan (CHIP).

OVERINSURANCE-DUPLICATION OF COVERAGE

We may refuse to issue a Conversion Policy if **We** determine that **You** would be overinsured. The Medical Conversion Policy will not be available if it would result in overinsurance or duplication of benefits. **We** will use **Our** standards to determine overinsurance.

Where overinsurance DOES NOT exist but other insurance is in force, benefits payable under the Medical Conversion Policy may be reduced.

MEDICAL CONVERSION PRIVILEGE (continued)

CONVERSION PLAN

The Conversion Policy which **You** may apply for will be the Policy customarily offered by **Us** as a conversion from group coverage.

The Conversion Policy is a new Policy and not a continuation of **Your** terminated coverage. The Conversion Policy benefits will differ from those provided under **Your** group coverage. The benefits that may be available to **You** will be described in an Outline of Coverage provided to **You** when **You** request an application for Conversion from **Us.**

EFFECTIVE DATE AND PREMIUM

You have 31 days after the date **Your** coverage terminates to apply and pay the required premium for **Your** Conversion Policy. The premium must be paid in advance. **You** may obtain application forms from **Us**. The Conversion Policy will be effective on the day after **Your** Group Medical coverage ends, if **You** enroll and pay the first premium within 31 days after the date **Your** coverage ends.

The premium for the Conversion Policy will be the premium charged by **Us** as of the effective date based upon the Conversion Policy form, classification of risk, age and benefit amounts selected. The premium may change as provided in the Conversion Policy.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

WHAT IS A PREFERRED PROVIDER ORGANIZATION?

Preferred Provider Organizations (PPO) are networks of **Hospitals, Qualified Treatment Facilities, Qualified Practitioners**, and other providers that are contracted to furnish, at negotiated fees, medical **Services** for **Employees** (and their covered **Dependents**) of participating **Employers**.

REASONS TO USE A PPO PROVIDER

1. **We** negotiate fees for medical **Services**. The negotiated fees lower costs for **You** when **You** use **Hospitals, Qualified Treatment Facilities, Qualified Practitioners**, and other providers in the PPO.

2. In addition, **You** may receive a better benefit and **Your Out-of-Pocket** expenses will be minimized.

3. **You** will have a wide variety of selected **Hospitals, Qualified Treatment Facilities, Qualified Practitioners**, and other providers in the PPO to help **You** with **Your** medical care needs.

In order to avoid reduced benefit payments, obtain **Your** medical care from Preferred Providers whenever possible. However, the choice of provider is **Yours**.

HOW TO SELECT A PROVIDER

A list of the participating **Hospitals, Qualified Treatment Facilities, Qualified Practitioners** and other providers in **Your** PPO will be given to **You** at the time **Your** coverage becomes effective. This list is subject to change. To confirm that **Your Hospital, Qualified Treatment Facility, Qualified Practitioner** or other provider is a current participant in **Your** PPO, you must call the number listed on the back of **Your** medical identification card.

If **You** are traveling or need emergency care and are unable to access care from **Your** PPO provider, benefits will be paid at the Non-Preferred Provider level.

MENTAL HEALTH COVERED SERVICES

The PPO Provisions may not include treatment received for **Mental Disorders**, Chemical or Alcohol dependence. Benefits for these conditions are shown under the Mental Health Covered **Services** provision of this Certificate and on **Your** Schedule of Benefits.

BENEFITS ARE PAYABLE AS SHOWN ON YOUR SCHEDULE OF BENEFITS.

UTILIZATION MANAGEMENT

PRESERVICE NOTIFICATION

This provision applies to all **Confinements** in a **Hospital** or **Qualified Treatment Facility** and non-emergency outpatient **Surgeries** in a **Hospital** or **Qualified Treatment Facility**. Nothing in this provision will increase benefits to cover a **Confinement** or **Service** which is not **Medically Necessary** or otherwise not covered under this Policy.

PRESERVICE NOTIFICATION PROCEDURES

WHAT YOU ARE REQUIRED TO DO:

If **You** or **Your** covered **Dependent** are to be admitted to a **Hospital** or **Qualified Treatment Facility** as an inpatient or for non-emergency outpatient surgery, **You** or **Your Qualified Practitioner** must contact **Us** by telephone or in writing at least seven days before **Your** admission. **We** must be notified of any Emergency admission within 48 hours after the admission or by the end of the first business day following the emergency which ever is later.

If **You** have pregnancy coverage and have not already notified **Us** as outlined under the **Prenatal Care** benefit, **You** must notify **Us** by telephone or in writing by the 20th week of pregnancy.

WHAT WE WILL DO:

We will advise **You** if **Preservice Review** and/or **Preauthorization** of the treatment plan is required by **Us** after **You** or **Your Qualified Practitioner** has provided **Us** with **Your** diagnosis and treatment plan.

If **Preservice Review** is necessary for the proposed treatment plans, **We** will:

1. Advise **You** if the proposed treatment plan is **Medically Necessary**; and

2. Advise **You** if **We** will continue to review **Your Confinement** or **Services** throughout the course of **Your Sickness** or **Bodily Injury**.

If **Preauthorization** is necessary for the proposed treatment plans, **We** will:

1. Advise **You** if the proposed treatment plan is a **Covered Expense**; and

2. Advise **You** if **We** will continue to review **Your Confinement** or **Services** throughout the course of **Your** covered **Sickness** or **Bodily Injury.**

If Your proposed treatment plan is determined at any time either partially or totally, not to be an eligible Covered Expense under the terms and provisions of this Policy, benefits will only be paid for Services (both Qualified Practitioner and Hospital or Quality Treatment Facility) that are determined to be eligible Covered Expense.

If **You** do not notify **Us** prior to an inpatient **Confinement**, non-emergency outpatient **Surgery** or within 48 hours of an emergency admission, benefits will NOT be payable for the first $500 of **Covered Expense**.

The $500 penalty is NOT applied to the **Deductible** or **Out-Of-Pocket Limit** shown on this Schedule of Benefits.

RIGHT TO CONSIDER SUBSTITUTION FOR COVERED EXPENSES

We reserve the right to consider for payment **Expenses Incurred** for **Services** which are substitutions for the **Covered Expenses** of this Policy. The expenses are considered at **Our** option and must:

1. Be **Medically Necessary**;
2. Have **Your** knowledge and agreement while receiving the **Service**;
3. Be prescribed and approved by **Your Qualified Practitioner**; AND
4. Offer a medical therapeutic value at least equal to the **Covered Service** that would otherwise be performed or given.

We may disallow a substitute **Service** at any time at **Our** sole option by sending a reasonable advance written notice to **You** and **Your Qualified Practitioner.**

COVERED MEDICAL SERVICES

This section describes **Services** which will be considered **Covered Expense(s)**. Benefits will be paid for such Covered Medical **Services** for a **Bodily Injury** or **Sickness** on a **Maximum Allowable Fee** basis and as shown on **Your** Schedule of Benefits subject to:

1. The **Deductible**, if applicable;

2. Any **Coinsurance** percentage; and

3. Up to any maximum benefit.

All other terms, provisions, limitations and exclusions listed in this Certificate are applicable to Covered Medical **Services**.

HOSPITAL SERVICES

Covered Expense includes charges made by a:

1. **Hospital** for daily semi-private, ward, intensive care or coronary care room and board charges for each day of **Confinement**. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the **Maximum Allowable Fee** charged for a semi-private room in the **Hospital** while a registered bed patient;

2. **Hospital** for **Services** furnished for **Your** treatment during **Confinement**;

3. **Free-Standing Surgical Facility** for **Services** furnished for **Your** treatment;

4. **Qualified Practitioner**, whether billed directly or separately by the **Hospital** for:

   A. Professional **Services** of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy; or

   B. Professional **Services** of an anesthesiologist;

5. **Hospital** or **Free-Standing Surgical Facility** for medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ;

6. **Hospital** for Outpatient **Services** when incurred for **Preadmission Testing**;

7. **Hospital** for Outpatient **Services** when incurred for **Emergency Care** due to a **Sickness**;

8. **Hospital** for Outpatient **Services** when incurred for **Emergency Care** rendered within 48 hours of an accident;

9. **Hospital** for Outpatient **Services** when incurred for a surgical procedure;

10. **Hospital** for Outpatient **Services** when incurred for regularly scheduled treatment such as chemotherapy, inhalation therapy, or radiation therapy as ordered by **Your** attending physician; and

11. **Hospital** for Outpatient **Services** not to exceed the average semi-private room rate when **You** are in **Observation Status.**

QUALIFIED PRACTITIONER SERVICES

Covered Expense includes charges made by a:

1. Physician for office, home or inpatient **Hospital** visits;

2. **Qualified Practitioner** for administration of anesthesia;

3. **Qualified Practitioner** for diagnostic x-ray or laboratory tests;

4. **Qualified Practitioner** for a surgical procedure, including post-operative care.

   If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the **Maximum Allowable Fee** for the primary surgical procedure and;

   A. 50% of the **Maximum Allowable Fee** for the secondary procedure; and

   B. 25% of the **Maximum Allowable Fee** for the third and subsequent procedures; and

5. **Qualified Practitioner** for services in performing certain oral surgical operations as follows:

   A. Excision of partially or completely unerupted impacted teeth;

   B. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

   C. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

   D. Reduction of fractures and dislocation of the jaw;

   E. External incision and drainage of cellulitis;

   F. Incision of accessory sinuses, salivary glands or ducts; and

   G. Frenectomy (the cutting of the tissue in the midline of the tongue).

COVERED MEDICAL SERVICES (continued)

JAW JOINT BENEFIT (Including TMJ)

Covered Expense incurred by **You** during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull, is payable up to $1,000 during each calendar year for **You** and each of **Your** covered **Dependents**.

The following are **Covered Expenses**:

1. A single examination including a history, physical examination, muscle testing, range of motion measurements and psychological evaluation, as necessary;

2. Diagnostic x-rays;

3. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of **Service**;

4. Therapeutic injections;

5. Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the **Maximum Allowable Fee** for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic **Services**, office visits, adjustments, training, repair and replacement of the appliance; and

6. Surgical procedures.

Covered Expense does NOT include charges for:

1. CT scans, magnetic resonance imaging except in conjunction with surgical management;

2. Electronic diagnostic modalities;

3. Occlusal analysis;

4. Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures; or

5. Any procedure not specifically listed as a **Covered Expense**.

PRENATAL CARE BENEFIT

Covered Expenses for **Prenatal Care** are ONLY payable up to the maximum amount as shown on the Schedule of Benefits when:

1. Notification of the pregnancy is received from the female **Covered Person** within one month after diagnosis of the pregnancy;

2. **Preauthorization** is received from **Us**.

Prenatal Care benefits DO NOT include any charges related to labor, delivery and post-delivery care UNLESS pregnancy is shown as a **Covered Expense** on the Schedule of Benefits.

PREGNANCY AND NEWBORN SERVICES

Normal pregnancy and well baby charges are **Covered Expenses** ONLY if shown as a **Covered Expense** on the Schedule of Benefits.

1. If provided, normal pregnancy charges are a **Covered Expense** for any female **Covered Person**. This benefit is payable after the exhaustion of the Prenatal Care Benefit.

2. **Complications of Pregnancy** are payable as any other covered **Sickness** at the point the complication occurs for any female **Covered Person**.

3. Well baby **Covered Expense** is **Expense Incurred** by a covered **Dependent** newborn child during his or her first five days of life for:

   A. **Hospital** charges for nursery room, board and care;

   B. The **Qualified Practitioner's** charges for circumcision of the newborn child; and

   C. The **Qualified Practitioner's** charges for routine examination of the newborn child before release from the **Hospital**.

Well baby coverage for newborns will be provided ONLY under the following circumstances:

   A. Normal pregnancy benefits are shown as a **Covered Expense** on the Schedule of Benefits; and

   B. The mother's delivery charges are a **Covered Expense** under the Plan.

4. For a covered pregnancy, **Hospital Services** for Inpatient care provided to the mother and the **Dependent** newborn child will be covered for:

   A. A minimum of 48 hours, following a vaginal delivery; or

   B. A minimum of 96 hours, following a cesarean section;

   UNLESS the following applies:

   A. Post-discharge office visit to the physician or in-home nurse visit is provided in the first 48 hours after discharge; or

   B. Earlier discharge is:

      i) Consistent with the most current version of "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists; and

      ii) Consented to by the mother and the attending physician.

5. Benefits for sick baby **Covered Expense** is payable for any covered **Dependent** newborn child. Sick baby **Covered Expense** is **Expense Incurred** by a covered **Dependent** newborn child for the following:

   A. Bodily Injury or Sickness;

   B. **Medically Necessary** care and treatment for premature birth;

   C. Medically diagnosed birth defects and abnormalities; and

   D. **Surgery** to repair or restore any body part necessary to achieve normal body functioning.

   Covered Expense does NOT include **Expense Incurred** for **Cosmetic Surgery**, EXCEPT **Surgery** for:

   A. Reconstruction due to **Bodily Injury**, infection or other disease of the involved part; or

   B. Congenital disease or anomaly of a covered **Dependent** child which resulted in a functional defect.

OTHER COVERED EXPENSES

The following are Other **Covered Expenses**:

1. Local professional ambulance service to the nearest **Hospital** equipped to provide the treatment is covered, if the **Bodily Injury** or **Sickness** requires special treatment not available in a local **Hospital**;

2. Blood and blood plasma which is NOT replaced by donation; administration of blood and blood products including blood extracts or derivatives;

3. Oxygen and rental of equipment for its administration;

4. Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. Replacement is a **Covered Expense** if due to pathological changes. **Covered Expense** includes repair of the prosthetic device if not covered by the manufacturer;

5. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;

6. Drugs and medicines that are required by law to be obtained on the written prescription of a **Qualified Practitioner**;

7. The rental, up to but not to exceed the purchase price, of a non-motorized wheelchair, hospital bed, ventilator, hospital type equipment or other **Durable Medical Equipment (DME)**. At our option, we may authorize the purchase of **DME** in lieu of its rental if the rental price is projected to exceed the purchase price of the **DME**. Repair or maintenance of the **DME** or duplicate **DME** rentals is not considered a **Covered Expense**;

COVERED MEDICAL SERVICES (continued)

8. The following special supplies, up to a 30-day supply, when prescribed by **Your** attending physician:

   A. Surgical dressings;

   B. Catheters;

   C. Colostomy bags, rings and belts;

   D. Flotation pads;

   E. Needles and syringes; and

   F. Initial contact lenses or eyeglasses following cataract surgery;

9. Dental treatment only if:

   A. The charges are incurred for treatment for a **Dental Injury** to a **Sound Natural Tooth**;

   B. The **Pre-Existing Condition** Exclusion period, if applicable, has been satisfied;

   C. The treatment begins within 90 days after the date of the injury; and

   D. The treatment is completed within 12 months after the date of the injury.

However, benefits will be paid only for **Expense Incurred** for the least expensive **Service** that will, in **Our** opinion, produce a professionally adequate result.

10. A baseline mammogram for a female **Covered Person** between the ages of 35 and 39 years; an annual mammogram for a female **Covered Person** 40 years of age or older;

11. Routine immunizations for **Covered Persons** under age 18. TB tine and allergy desensitization injections are not considered routine immunizations;

12. For a female **Covered Person**, an annual cervical smear or Pap smear test;

13. For a male **Covered Person**, 40 years of age or older, an annual digital examination and a prostate-specific antigen (PSA) test, when recommended by a **Qualified Practitioner;**

14. Colorectal examinations and laboratory tests for colorectal cancer as prescribed by a physician and in accordance with the American Cancer Society guidelines on colorectal cancer screening or other colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

15. For a **Covered Person**, who is receiving benefits in connection with a mastectomy, **Services** for:

   A. Reconstructive surgery of the breast on which the mastectomy has been performed;

   B. Surgery and reconstruction of the other breast to achieve symmetrical appearance; and

   C. Prostheses and physical complications from all stages of mastectomy, including lymphedemas;

COVERED MEDICAL SERVICES (continued)

16. Following a mastectomy, **Medically Necessary** length of stay for inpatient care and post-discharge office visit to the physician or in home nurse visit provided in the first 48 hours after discharge.

    For the purposes of this provision, "mastectomy" means the removal of all or a part of the breast for medically necessary reasons, as determined by a licensed physician;

17. Any Drug approved by the Federal Food and Drug Administration (FDA) and used in the treatment of neoplasm, regardless of whether the drug was approved by FDA for the treatment of the specific neoplasm for which the drug is being used, if all the following conditions are met:

    A. The drug is ordered by a physician for the treatment of a specific type of neoplasm;

    B. The drug is approved by the Federal Food and Drug Administration for use in anti-neoplastic therapy;

    C. The drug is used as part of an anti-neoplastic drug regimen;

    D. Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and

    E. The physician has obtained informed consent from the patient for the treatment regimen which includes Federal Food and Drug Administration approved drugs for off-label indications; and

18. Patient care costs for blood tests, x-rays, bone scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally incurred in standard cancer treatment for a **Covered Person** who is:

    A. Diagnosed with a terminal condition related to cancer; and

    B. Is participating in an approved cancer research trial in Phase II, Phase III or Phase IV of investigation.

19. **Hospital** or **Free-Standing Surgical Facility Services** and anesthesia charges associated with dental procedures for the following **Covered Persons**:

    A. A child age six or under;

    B. An individual who has a medical condition that requires hospitalization or general anesthesia for dental care;

    C. An individual who is disabled.

20. If **Medically Necessary**, coverage for bone mass measurement and treatment for osteoporosis.

PHYSICAL MEDICINE BENEFIT

Covered Expense for outpatient Physical Medicine is payable to a maximum benefit amount as shown on the Schedule of Benefits. Physical Medicine expenses include charges incurred during the diagnosis and treatment of physical conditions relating to bone, muscle or neuromuscular pathology, including but not limited to, speech, physical, occupational, growth and cognitive therapies; biofeedback; rolfing; adjustments and manipulations of any spinal or bodily area; and cardiac exercise programs.

Treatment of cerebral vascular accidents (CVA), burns, fractures or related conditions for which **You** are hospitalized or had **Surgery** and when Physical Medicine immediately follows discharge, is payable as any other **Sickness** or **Bodily Injury** and is not limited to the Physical Medicine Benefit.

SKILLED NURSING FACILITY BENEFIT

Covered Expense for daily room and board and general nursing services for each day of **Confinement** in a **Skilled Nursing Facility** is payable for up to 30 days during each calendar year when **Preauthorization** is received from **Us.**

A **Skilled Nursing Facility Confinement** means only a **Confinement** in a **Skilled Nursing Facility** which occurs when **You** are under the regular care of a **Qualified Practitioner** who has reviewed and approved the **Confinement.**

Preauthorization is required by **Us.** If **Preauthorization** is not received from **Us,** NO benefits will be payable under this Policy for **Skilled Nursing Facility** care.

HOME HEALTH CARE BENEFIT

Covered Expense for Home Health Care as described below is payable under this Policy. A **Home Health Care Provider** must render **Services** at **Your** home under a **Home Health Care Plan,** as described below. The **Home Health Care Plan** must begin within 14 days after discharge from a **Hospital, Qualified Treatment Facility** or **Skilled Nursing Facility,** unless waived by **Us.** Nothing in this provision will increase benefits to cover Home Health Care **Services** which are not otherwise covered under this Policy.

The maximum benefit per **Covered Person** is 100 **Home Health Care Visits** per calendar year as shown on **Your** Schedule of Benefits.

Covered Expense is only payable when:

1. **Preauthorization** is received from **Us**; and

2. **Home Health Care** is in lieu of a covered **Confinement** in a **Hospital, Qualified Treatment Facility** or **Skilled Nursing Facility**

If the above criteria are not met, NO benefits will be payable under this Policy for Home Health Care.

Home Health Care benefits do NOT include:

1. Charges for mileage or travel time to and from the **Covered Person's** home;

2. Wage or shift differentials for **Home Health Care Providers**; or

3. Charges for supervision of **Home Health Care Providers.**